Maximising efficiency in psychological professions' training routes

A report commissioned by the National Workforce Skills Development Unit and Health Education England

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Executive summary

The Maximising Efficiency in Psychological Professions' Training Routes project examined the content of training programmes for psychological wellbeing practitioners (PWP), children's wellbeing practitioners (CWP) and education mental health practitioners (EMHP). Its primary aim was to identify commonalities and differences across these programmes, and hence ascertain whether there is scope for improving the efficiency of training in this area.

The overall structure, areas of teaching, and the knowledge and skills developed by each programme were identified through analysis of their curricula. This information was complemented by stakeholder input and a nationwide consultation with course directors, and summarised in a 'matrix' showing the features of each programme.

Key findings

- Although all three courses have a broadly similar overall structure, PWP training differs significantly from that undertaken by CWPs and EMHPs owing to fundamental differences in the knowledge and skills required to work with adults and children, and differences in service contexts, which shape the ways that these skills are practised. These differences are most marked in:
    - assessment skills
    - communication and engagement skills
    - outcome monitoring
    - safeguarding
    - the care models employed.
- While CWP and EMHP training programmes share many similarities in their teaching content and skills, there are distinct areas of difference that reflect the service context associated with each role.

These findings led to a number of conclusions regarding the scope for increasing efficiency among the training routes:

- Differences between adult- and child-focused programmes are too substantial for movement between roles to be facilitated by a shortened training programme.
- The two child-focused programmes may be similar enough to consider 'top-up' training that allows practitioners to transition between roles; such training would likely centre around the different contexts in which CWPs and EMHPs operate.
- The CWP and EMHP roles are very new and continue to develop; the distinction between them should be explicitly clarified.
- Before developing training that facilitates easier movement between the roles, there is first a need to investigate whether there is sufficient demand to make this a worthwhile endeavour.

1. Background

To respond to a growing need for mental health care, the landscape of mental health provision in England has undergone significant change over the past decade.[1–3] New services and teams have been established and additional roles have been created to ensure that there is sufficient workforce to meet that need. A role that is able to meet the needs of those with common mental health problems is a critical component of an effective workforce. Three such roles exist across the various services:

- adult PWPs work within Improving Access to Psychological Therapies (IAPT) services[a]
- CWPs operate as part of an expanded children and young people’s mental health workforce across various agencies and services and started recruiting trainees in 2017
- EMHPs operate within mental health support teams (MHSTs)[b] and are based in schools and colleges; the training was rolled out in 2019.

These roles are commissioned by the NHS, but practitioners can be found in settings other than NHS services.

Although the practitioners operate within distinct services, the roles were created to provide low-intensity, evidence-based psychological interventions to people with common mental health problems of a mild to moderate nature, in a stepped care delivery model. The aim is to match the intensity of care to the person’s needs. The practitioners work with people who may benefit from low-intensity input, whereas high-intensity interventions are focused on those whose needs are not met within a low-intensity setting or those whose presentation is more complex or severe. This allows for more efficient use of resources and enables services to support a greater number of individuals with treatment that meets their specific needs.

Each of these roles was conceived as a separate role with distinct training paths. To work as a qualified practitioner, a candidate needs to complete the training course specific to the role. At present, to move between the roles, they need to complete the full training associated with the new role. Given the potential overlap in the type of interventions that are delivered, they could be re-learning skills and competences with which they are already familiar. It is worth evaluating whether the efficiency of training routes can be improved to facilitate practitioners’ transition between roles by modifying the requirement to complete the training programme associated with another role. Whether this would be possible is a question rooted in an analysis of the content of the training courses.

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[a] IAPT was established in 2008 to meet the common mental health needs of adults within the community. In 2011, CYP IAPT was set up with a remit broadly similar to adult IAPT, but focused on children and young people and their families.

[b] MHSTs are teams set up during 2018 and 2019 in educational settings to provide evidence-based support, care and interventions to children and young people with mild to moderate mental health problems.

2. Project scope

This report is part of a larger project looking at how to increase efficiency in training routes for adult PWPs, CWPs and EMHPs. The project was commissioned by Health Education England (HEE) and is being managed by the National Workforce Skills Development Unit (the Unit).

At project scope, we have analysed the knowledge and skills required by each of the roles, as indicated by their respective training programmes, and identified similarities and differences. We aimed to answer the following questions:

1. What are the areas of knowledge and skills specific to each role?
2. Are there areas of knowledge and skills shared across the roles, and if so, what are they?
3. Does the pattern of shared and distinct competences have implications for increasing the efficiency of the training routes into these roles?

This analysis supports the wider work that is being completed in this area by the Unit.

2.1. Training programmes

This project focuses on the skills and competences set out in the curricula and training programmes for adult PWPs, CWPs and EMHPs.

Each of these roles focuses on low-intensity evidence-based interventions for people with common mild to moderate mental health problems.

2.2. Audience

This work is being developed to inform HEE about possibilities for more efficient ways of training. It will also be useful for commissioners and providers of services, particularly in relation to recruiting staff.

3. Overview of roles and training requirements

3.1. Adult psychological wellbeing practitioner role

The adult PWP role was developed as part of the IAPT programme, in line with recommendations from The Five Year Forward View for Mental Health.[4]

Adult PWPs sit within step 2 of the IAPT stepped care model, comprising the workforce responsible for the provision of high-volume, low-intensity psychological interventions (low-intensity cognitive behavioural therapy [CBT], psychoeducation, guided self-help) to adults with mild to moderate anxiety and depressive disorders. The IAPT Manual, prepared by the National Collaborating Centre for Mental Health (NCCMH) on behalf of NHS England, outlines the IAPT service model in full.[5]

3.1.1. Outline of the adult PWP training course

PWP training takes place across one calendar year, with a 45-day curriculum consisting of academic teaching (25–30 days) and directed practice-based learning (15–20 days). Trainees spend non-teaching days working within services.

A national curriculum applies to all adult PWP training. It is divided into three modules:

- engagement and assessment of people with common mental health problems
- evidence-based low-intensity treatment for common mental health problems
- values, diversity and context.

Throughout the course, PWP trainees are expected to undertake 80 clinical contact hours with patients, 15–20 days of directed practice-based learning and receive 40 hours of supervision: 20 hours of case management and 20 hours focused on developing clinical skills. To qualify, PWP trainees must complete two assignments and a set of practice outcomes for each of the three modules. Examples of assessment formats include:

- a standardised role-play scenario simulating clinical situations
- video recordings of a real-life low-intensity session with a patient
- a practice outcomes portfolio
- an assessment of ethics and reflective practice
- academic assignments such as exams, case reports and essays.

The PWP national curriculum outlines the learning outcomes that each PWP trainee needs to achieve by the end of their training course. These learning outcomes comprise academic skills (knowledge, understanding and analytic) as well as clinical skills (interpersonal, practical and decision making).[6]

PWP programmes lead to the award of a graduate or postgraduate certificate and are accredited by the British Psychological Society (BPS). The learning outcomes from the national curriculum are incorporated into the BPS accreditation standards.[7]

Trainees are paid at Agenda for Change (AfC) band 4; once qualified, they are appointed to AfC band 5.

According to HEE, 385 PWP trainees commenced training in England between April 2018 and March 2019.[c]

3.1.2. Entry requirements

The principal entry requirement for PWP programmes is experience of having worked with adults with psychological, interpersonal or social problems in a professional or voluntary capacity.

Academic requirements are less specific and may differ between higher education institutions (HEIs). Candidates must evidence their ability to study at postgraduate level, for example, by possessing a psychology or other health-related degree.

3.1.3. A day in the life of a newly qualified PWP

The role of a newly qualified PWP varies day to day but a typical day may begin with a morning of triaging new referrals via a telephone assessment to determine the most suitable next steps for support – low-intensity, high-intensity or an onward referral to another organisation. The remainder of the day is then generally spent delivering low-intensity interventions in clinics, which may be face to face, over the telephone or as computerised CBT. Newly qualified PWPs deliver all of their clinical work independently and are usually expected to manage a full caseload of up to eight patients a day, therefore supervision is imperative in supporting them in this role. Regular case management supervision of 1 hour a week should be made available to newly qualified PWPs. In supervision, they can discuss their assessments/treatments to consider which treatment pathway or intervention is appropriate to the person's needs; this can also involve signposting or referring to alternative services.

Organisational skills are a vital part of the role; the last part of the day is spent catching up on outstanding tasks or admin, which may consist of client notes, writing letters or onward referrals.

3.2. Children's wellbeing practitioner role

The ambitions for the CWP programme were outlined in Implementing the Five Year Forward View for Mental Health.[8] This highlighted the aspiration to offer evidence-based interventions to an extra 70,000 children and young people each year from 2020, realised by training an additional workforce of 1,700 practitioners from 2016 to 2020 to close the gap in provision.

The CWP role is located within the CYP IAPT programme. It is designed to provide support to children and young people who experience common mental health problems that are mild to moderate in nature.[4] The main objectives of CYP IAPT are to improve access to support from community services, reduce waiting lists to wider children and young people's mental health services, offer evidence-based treatment for children and young people, and optimise referrals to wider children and young people's mental health services by triaging referrals through a stepped care model. CWPs are an integral part of this stepped care approach and play a key role in the early intervention and prevention of mental health problems.

CWP trainees are paid at band 4 and are appointed to band 5 once qualified.

[c] HEE, personal communication, 2019.

Data available from HEE[d] indicate that three cohorts of trainees commenced the CWP course across England in April 2018, January 2019 and September 2019 (data for the first cohort of trainees from September 2017 were unavailable). Each cohort consisted of 210 trainees, with a further 210 due to commence CWP training in January 2020. Supervision training is commissioned by HEE alongside the CWP programme.

3.2.1. Outline of the CWP training course

Training takes place over one calendar year. There are 40 academic teaching days in total, but the structure of the programme typically varies across academic terms. Most training organisations will prioritise teaching content at the start of the course, with a higher number of teaching days that taper down as the year progresses. On non-teaching days, trainees undertake supervised practice in a service as well as self-study.

CWP training consists of three modules:

- children and young people's mental health settings: context and values
- assessment and engagement
- evidence-based interventions for common mental health problems with children and young people (theory and skills).

Table 1: Example CWP training programme term structure[e]

Term 1	Term 2	Term 3
3 teaching days 2 days of supervised practice	1 teaching day 4 days of supervised practice	Full-time supervised practice with protected study time

During training, CWPs undertake 80 hours of clinical practice and receive 40 hours of supervision: 20 hours on case management and 20 hours focused on developing clinical skills.

To qualify, trainees must complete:

- a minimum of ten cases covering a range of difficulties including anxiety, low mood and behavioural difficulties, in addition to evidence of working with parents and school staff
- various academic assignments (reflective analyses and case reports) and video recordings demonstrating clinical skills.

CWP courses are not currently professionally accredited.

3.2.2. Entry requirements

Applicants must provide evidence of their ability to study at postgraduate level, for example through possession of a second-class undergraduate degree in a relevant subject (psychology-, health- or social care-related). They also need evidence of experience of working with children and young people.

[d] HEE, personal communication, 2019.

[e] This outline is based on the description and structure of the CWP training programme delivered by University College London (UCL). While efforts have been made to provide a mostly generic overview, there may be some variability between training locations across the country.

3.2.3. A day in the life of a CWP

A CWP has a varied job, which will look slightly different depending on the organisation they work in. The team may be employed by the NHS and connected to a child and adolescent mental health service (CAMHS), although CWPs tend to work mostly with individuals who do not meet the threshold for a tier 3 service (specialist community CAMHS). CWPs work with young people with anxiety of low to moderate intensity, low mood and behavioural difficulties. They also run psychoeducational workshops and groups in a variety of school and community settings on topics connected to these core interventions and mental health promotion. Once a CWP is qualified, they can work with slightly more complex cases than when they were training but still for the purpose of providing low-intensity psychological interventions for anxiety and/or low mood (e.g. a child or young person on the waiting list for a CAMHS assessment for autistic spectrum disorder or attention-deficit hyperactivity disorder (ADHD), a person with higher risk), and take more responsibility for other aspects of the work (e.g. setting up and running groups, screening referrals).

A typical day might be going to a school or a youth club/hub to run a parent or young person workshop in the morning, then coming back to the office for the CWP screening meeting at lunch time. They might then hold a face-to-face meeting and a shorter telephone session with a child, young person or parent, followed by a screening call in the afternoon. A CWP might then facilitate the youth board towards the end of the day, when school is finished. Importantly, CWPs receive a lot of support from the supervisor and service lead.

3.3. Education mental health practitioner role

Establishing the EMHP role and MHSTs in which they operate was one of the three proposals set out in Transforming Children and Young People's Mental Health Provision: A Green Paper[9] that focused on improving mental health by locating services within educational settings.

EMHPs will represent the majority of the MHST workforce and are expected to play a fundamental role in delivering the three core functions of an MHST:

1. providing support in an education setting for a whole-system approach to the mental health and wellbeing of children and young people
2. delivering evidence-based support, care and interventions for children and young people with mild to moderate mental health problems, and their parents/carers and families
3. signposting and supporting children and young people with complex needs to get the right help.

EMHPs are seen as a key part of the workforce involved in the early intervention and prevention of mental health problems.

Trainees are paid at band 4 and qualified EMHPs are appointed to band 5.

According to data from HEE,[f] the first cohort of 220 EMHP trainees in England commenced training in January 2019, followed by a second cohort of 250 in September 2019. Another group of 250 started training in January 2020. Supervision training has been commissioned by HEE alongside the EMHP training course.

[f] HEE, personal communication, 2019.

3.3.1. Outline of the EMHP training course

Training takes place over one calendar year divided into three terms. Supervised practice and approximately 64 academic teaching days comprising six modules are distributed across the terms (see Table 2). The modules are:

- children and young people's mental health settings: context and values
- assessment and engagement
- evidence-based interventions for common mental health problems with children and young people (theory and skills)
- working, assessing and engaging in education settings
- common problems and processes in education settings
- interventions for emerging mental health problems in education settings.

Table 2: Example EMHP training programme term structure[g]

Term 1	Term 2	Term 3
3 teaching days 2 days of supervised practice	2 teaching days 3 days of supervised practice	1 teaching day 1 protected learning/study day 3 days of supervised practice

EMHP trainees undertake 80 hours of clinical practice and receive 40 hours of supervision, comprising 20 hours of case management and 20 hours focused on developing clinical skills.

Throughout the training programme, EMHP trainees are expected to complete:

- a minimum of eight cases covering a range of difficulties including anxiety, low mood and behavioural difficulties, in addition to evidence of working with parents and educational staff
- assessment of competences through live demonstration or video recording
- a written report on the delivery of a psychoeducational workshop
- a written report on the delivery of a group intervention
- a written report on 'measuring wellbeing in educational settings'
- academic and service-based learning portfolios.

The EMHP role is a 2-year funded post; the first year of funding pays for the training post and the second funds employment within an MHST.

EMHP courses are not currently professionally accredited.

3.3.2. Entry requirements

While requirements may differ between training sites, candidates for EMHP training must demonstrate their ability to study at a postgraduate level, for example through possession of at

[g] This outline is based on the description and structure of the EMHP training programme delivered by the UCL. While efforts have been made to provide a mostly generic overview, there may be some variation in the structure of EMHP programmes between training locations across the country.

least a 2.2 in a psychology-, health- or education-related degree. They must also evidence experience of working with children and young people.

3.3.3. A day in the life of an EMHP

The day-to-day work of an EMHP will vary depending on the MHST and the setting in which they work. At present, EMHPs provide brief low-intensity interventions for mild to moderate mental health problems (anxiety, low mood and challenging behaviour) in educational settings, comprising individual work with young people, their parents or carers, or work in groups. EMHPs may also offer psychoeducational workshops to young people, their parents, carers or the teaching staff, on common difficulties experienced by young people in school, such as exam stress and transitions. Under supervision, EMHPs may work closely with schools to develop whole-school approaches to emotional wellbeing, such as peer mentoring schemes.

A typical day might include facilitating a coffee morning with parents, seeing two or three young people for anxiety or low mood, or parent work for children who experience anxiety or present with challenging behaviour. An EMHP may then travel to another school in the local area to deliver a psychoeducation workshop or group intervention. EMHPs will typically meet with the school's special educational needs coordinator (SENCO) to provide any updates on cases and raise any safeguarding concerns. They may also speak to teachers who are concerned about children/young people in their class and help with signposting.

4. Project method

To undertake an analysis of the current training and role descriptions, the project was structured as follows.

1. **An analysis of the curricula for each of the three roles.** A 'matrix' was developed, which identified the knowledge and skills (and therefore the competences) associated with each role and permitted a detailed comparison of their commonalities and differences.

   While there is a national (and therefore, standardised) curriculum for adult PWPs, those for CWPs and EMHPs are developed by each course. As such, identifying the curricula of each training programme and collating their details would be a major undertaking and beyond the resources of this project. Therefore, a pragmatic decision was made to focus on the three London programmes offering PWP training: the adult programme based at the UCL and the CWP and EMHP programmes based across the Anna Freud Centre, UCL and King's College London. We are aware that this carries the risk of an unrepresentative characterisation of these roles; step (3) is intended to mitigate this.
2. **Course directors' involvement.** The course directors of the UCL-based programmes were consulted to review the analysis of the programmes. They assisted the research team in identifying the broader issues related to training and the question of efficiency being addressed by this project.
3. **Stakeholder group circulation.** To ensure that the analysis reflected the national picture (and guard against it being 'London-centric'), a draft of this report and its conclusions was circulated to all known directors of PWP, CWP and EMHP programmes in England, along with a smaller number of commissioners and academics directly involved with implementing these programmes. They commented on the extent to which the report represented their own appraisal of the structure and content of training, and whether its conclusions were valid.

4.1. Development of a competence matrix

Materials and resources that identify the skills and knowledge associated with the PWP, CWP and EMHP training routes were obtained from each of the programmes.

4.1.1. PWP

- National Curriculum for the Education of Psychological Wellbeing Practitioners, third edition[6]
- UCL's PWP teaching programme timetable
- UCL's information pack for applicants to the PWP programme
- Assessment and intervention mark sheets for the UCL PWP programme
- Widening Participation to Psychological Wellbeing Practitioner Training report[10]
- PWP Best Practice Guide[11]

4.1.2. CWP

- HEE's outline curriculum for CWP training
- UCL and Anna Freud Centre's CWP programme module aims, content and objectives
- UCL and Anna Freud Centre's programme handbook for CWP trainees, including a competence framework

- UCL and Anna Freud Centre's CWP teaching programme timetable

4.1.3. EMHP

- HEE's EMHP curriculum
- UCL and Anna Freud Centre's EMHP programme handbook for new trainees
- UCL and Anna Freud Centre's EMHP teaching timetable

A detailed extraction of competences was performed (this was consolidated into a spreadsheet available in the supplementary material: matrix of competences). We started by overviewing the skills and knowledge set out in these materials and developing an outline structure that identified the major components of the training. This was refined and revised as extraction continued and broadly reflects the usual structure of competence frameworks (setting out basic areas of knowledge before moving on to the processes of engagement, assessment, intervention and evaluation).

One challenge to this process is that the curricula for each programme differ markedly. The adult PWP national curriculum outlines necessary content, but at a fairly high level of description; in contrast, the curricula for CWP and EMHP are highly detailed and granular. For this reason, the national adult PWP curriculum was supplemented by the teaching programme and by cross-checking of content with the relevant course director.

4.2. Course director and stakeholder consultation

The project included two forms of consultation: face-to-face meetings with course directors of the London programmes and consultation via email with course directors (stakeholders) of all the programmes across England.

4.2.1. Course director meetings

Two meetings were convened with the course directors responsible for leading the PWP, CWP and EMHP training programmes at UCL. The directors provided comprehensive feedback on the competence matrix, as well as practical insights concerning key areas of similarity and difference between the training routes that may not be adequately reflected in the source materials. They also offered their perspectives on the current context for training and any challenges that HEIs might be facing in terms of trainee recruitment and retention, and on the potential for improving efficiency between training routes.

4.2.2. Stakeholder consultation

After the matrix had been refined in light of feedback from the course directors, it was circulated, along with a draft of this report, to directors responsible for leading the three training programmes at locations nationwide. They were invited to comment on its accuracy and applicability to their own programme, and to express their views as regards any conclusions to be drawn from the analysis of the matrix (see the **Appendix** for a summary of the stakeholder consultation and a list of the organisations involved).

4.3. Retention

4.3.1. PWP

Once qualified, retention is a key issue for HEIs and services because there is a high turnover in the PWP workforce. The 2015 IAPT census[12] reported turnover rates of 22% for PWPs

compared with just 9% among the high-intensity workforce. PWP course directors identified burnout as a significant factor for a high turnover, with many PWPs feeling their caseload was unmanageable and unsatisfying in the medium to long term. Many leave the role to apply to high-intensity courses or move to other training (such as the Doctorate in Clinical Psychology).

4.3.2. CWP and EMHP

The CWP role also faces challenges over retention, though in this case, retention issues are driven by an apparent lack of available funded posts extending beyond training positions. As a consequence, CWPs are often obliged to seek alternative roles or training shortly after qualifying.

A further issue impacting on both CWPs and EMHPs is a lack of opportunities for career progression once in post. Unlike PWPs, there is no opportunity to progress to a 'senior' practitioner; the only way of advancing their career is to move on to work in a different mental health role, or to take up training in an alternate role (for instance, in clinical or educational psychology).

The issue of limited career progression for CWPs and EMHPs is recognised as substantial by stakeholders. In a briefing paper looking at ways to maximise the impact of MHSTs,[13] the BPS have identified a clear career pathway, in which practitioners can 'continually build their skills and progress within the new structures rather than being obliged to leave in order to further their careers elsewhere', as a core recommendation to make these new roles successful.

4.3.3. Evidence of transfer across roles

In relation to the London programmes, the course directors indicated that there have been no examples of individuals completing one low-intensity training and subsequently applying to re-train in another. However, anecdotally they were aware of adult PWPs who have applied for CWP positions after qualifying. This raises a concern as to whether the applicants have the necessary specific knowledge and skills to carry out a CWP role.

Nationwide, course directors reported a flow from CWP training to PWP, again owing to the lack of available CWP roles. However, this similarly raises an issue as to whether the context of their training with children and young people will have prepared them to work effectively with adults.

5. Results

5.1. Overview of the matrix

The matrix shows the knowledge and skills associated with each programme and enables a comparison of their content (see supplementary material: matrix of competences). It contains two parts:

1. an overview of the basic structure of the three programmes
2. a disaggregation and comparison of the skills and knowledge included in the teaching programmes.

5.1.1. Basic structure of the three training programmes

There is considerable similarity in the basic structure of training across the three programmes. Each programme requires evidence of an ability to study at the graduate level, usually through the possession of a relevant undergraduate degree or similar (such as a level 5 or 6 qualification). The duration of training is the same (1 year). Trainees are required to work with a similar number of cases, to undertake academic assignments that mirror the teaching and to report on the clinical work. Despite the congruence in their basic structure, the PWP and CWP programmes tend to award a postgraduate certificate, while the EMHP programme is usually a postgraduate diploma, reflecting the greater teaching and training time associated with an EMHP course.

5.1.2. Comparison of knowledge and skills

The analysis and comparison of skills and knowledge is divided into a number of content areas, as follows.

Values and diversity

Each programme ensures that trainees are aware of, and practise in line with, values associated with diversity and equality of access, thinking about the impact of unequal power relationships and ways of minimising these.

Professional knowledge

The term as used here applies to issues of legislation, confidentiality and consent. Each programme offers a thorough grounding in these and covers similar focus areas.

Knowledge of context and settings

All programmes ensure that trainees are appropriately oriented to the contexts in which they will be working. However, it is worth acknowledging that although this is a structural similarity, the content of the three courses differs markedly, in terms of not only the client groups but also the clinical and institutional settings in which the practitioner will be working.

Knowledge of basic clinical issues

All programmes ensure that trainees are informed about the types of mental health needs with which they will be working and understand the stepped care model and the place of self-help (low-intensity) interventions within this. However, the two child programmes differ from the adult training in their emphasis on developmental issues, and the EMHP programme differs from the

CWP programme by including consideration of educational issues and the ways in which the educational system affects how children and young people present to services.

Knowledge of evidence-based treatment options

All programmes ensure that trainees are familiar with (and appropriately critical of) the evidence base for low-intensity interventions, aware of the low-intensity options being offered, and understand the links between low- and high-intensity approaches.

Communication skills and engagement/alliance building

All programmes cover similar areas, ensuring that trainees are aware of their own communication style and can adapt it to the needs of the person they are working with. They should also be able to use these skills to build a working alliance with the person. However, while the adult training focuses on the individual person, the child programmes place a strong emphasis on the need to relate to both the child and to their family and the system within which they are located, making the engagement process rather different.

Assessment skills

All programmes offer a grounding in the use of quantitative and qualitative measures, and instruction in the use of an assessment that is structured in such a way as to help to plan an intervention. However, both child programmes encourage trainees to make use of some systemic techniques during the assessment process. In contrast, the adult PWP assessment process is focused on the person, albeit with some attention to their wider social context.

All three programmes emphasise the importance of competence in risk assessment, formulation and management for practitioners, though (reflecting their target population) the child programmes place additional focus on safeguarding.

Planning the intervention

All programmes share a broadly similar approach that fosters collaboration with the person and ensures that they are informed about the rationale and goals for interventions and the available options.

Offering low-intensity interventions

Although there is overlap across programmes in their outline structure – all prepare trainees to deliver low-intensity interventions in a planned and thoughtful manner – the specifics of the interventions being offered vary markedly when comparing the adult with the child-focused programmes. As far as the latter are concerned, much more attention is being paid to the family and educational contexts, where some of the skills acquired by service users may be being put into practice.

Managing endings/relapse prevention

All programmes help trainees consider how to ensure that there is a planned ending that usually also includes a relapse prevention plan to assist this.

Team working skills

All programmes help trainees consider issues related to team working, whether with colleagues within their own team or in external agencies. However, the content and emphasis of each programme are necessarily different, with a focus on adult IAPT, CAMHS and the education context as appropriate.

Reporting, record keeping, outcome monitoring

Outcome monitoring is routine in services, as is accurate recording and record keeping; as such their underpinning principles are covered in all three programmes. The content of training varies, however, reflecting the fact that adult and children's services will use different outcome measures, as well as the need for trainees to be aware of how the professional context shapes the way in which record keeping is managed and shared.

Supervision/reflective practice

All programmes place a similar emphasis on the need for trainees to develop a capacity for accurate self-reflection and the skills needed to make an active contribution to supervision.

5.1.3. Comparison of areas of teaching

Necessarily, programmes convert their curricula into a teaching timetable, and a comparison of the areas being taught provides an alternative way of detecting commonalities and differences.

5.2. Key differences

Given the nature of the programmes, it would be surprising if there was no overlap between them. This is reflected in the fact that a series of common headlines can be used to cluster the competences for each course, pointing to some shared structural similarity. However, there are key differences in the *content* of the adult and child programmes, and these manifest in:

- the content of teaching
- the knowledge and evidence base for the adult and child programmes
- the service context in which skills are applied
- the populations to whom interventions are addressed
- the clinical skills that are used in everyday practice and the theoretical models that guide them.

Because this is a crucial point, it is helpful to detail some concrete examples of the ways that work with adults and children can appear to have the same structure, but in practice the knowledge and skills being taught are very different.

- **Assessment skills** – All programmes ensure that trainees are equipped to perform an assessment, but its content, style and range will differ markedly. At a fundamental level, assessments for adults usually focus on the individual, whereas those for children and young people will involve coordination and communication with the system around the child (e.g. parents, carers, education system). The assessment tools used and the ways in which they are administered will also differ.
- **Communication and engagement skills** – All PWPs need to learn how to apply communication skills in order to develop a therapeutic relationship with their clients. However, CWPs and EMHPs need to draw on knowledge of the ways that the child's or young person's developmental level impacts on their comprehension of events. They then need to apply this knowledge by adapting their communication style, so that all communication considers the child's or young person's developmental stage, a process that is critical for engagement.
- **Outcome monitoring** – This is routine across all programmes, but the type and range of measures used differ markedly, as do the procedures used to administer them and to interpret their results.

- **Safeguarding** – In relation to children, safeguarding and maintaining confidentiality raises specific issues that are not pertinent in the adult context, such as parental rights, information sharing and involving different agencies, processes, priorities and requirements.
- **Care models** – Although most of the interventions offered by all three courses are rooted in CBT, the models on which they are based differ. This reflects the fact that rather than extrapolating from approaches used with adults, interventions for children are based on child-specific models – using similar principles, but with clear differences in delivery and focus to an adult context.

5.2.1. Differences between the CWP and EMHP programmes

There are clear commonalities between the child programmes, with overlapping content as well as structure. However, there are some significant differences that need to be noted. For example:

- EMHPs are exclusively based in educational settings, whereas CWPs work across a range of settings, including health services, community groups and educational settings; as such, trainees in each programme will be exposed to a different experience of the systems in which services are offered and the ways in which these are navigated
- differences in service context are reflected in additional training provision for EMHPs, with three modules focused on delivering their role in an educational context, in addition to the three modules they share with CWP training
- EMHPs are trained to offer whole-school interventions (such as universal prevention programmes), as well as individual sessions with children, meaning that they may hold individual sessions less frequently than CWPs
- EMHPs also engage in more indirect working by offering consultations to teaching staff.

6. Conclusions

6.1. Scope for increasing efficiency in training routes

The focus of this report was to identify the potential for allowing individuals who are already trained as a wellbeing practitioner to switch roles without undergoing a full 1-year training programme, as is required at present. This could have some key benefits, such as:

- improving recruitment and retention rates in the low-intensity workforce, by:
  - providing opportunities for work in different settings with different populations
  - learning new skills and acquiring experiences that would offer opportunities for career development
- helping services to recruit into roles that may currently be under-resourced by enabling their workforce to transfer skills into different contexts.

Although there is clear logic to this aspiration, our analysis indicates that there are major differences between the adult and child PWP programmes. This means that individuals wishing to transfer would need to acquire a broader range of knowledge and skills, including familiarity with the complexity of the child or young person's care and the educational context. Acquiring these additional skills and knowledge would be challenging without undertaking the relevant additional course. Although there would be some gain from their previous training, the scope for offering shortened training programmes is minimal, and hence not particularly advantageous for trainees, training bodies or commissioners.

A comparison of the two child programmes suggests that they have much in common in terms of the knowledge and skills they teach (indeed, some EMHP courses already include the initial CWP modules, meaning that the curricula share some of the core knowledge and skills). However, there are important differences in the contexts in which trainees work and the types of service delivery associated with these contexts. As such, transfer across the two child programmes with a shortened course does seem feasible, for example through a top-up programme that supplements the pre-existing qualifications and experience by focusing on acquiring the skills relevant to these different contexts.

- For a CWP to transition to an EMHP role, top-up training might include teaching and placement experience that enables them to work in the educational context (e.g. delivering universal prevention through whole-school approaches, providing consultation to teachers, detailed knowledge about the education system). These areas of knowledge and skills are currently taught in modules 4 to 6 of the EMHP national curriculum and would need to be completed in addition to the CWP competences for use in individual sessions in education settings.
- For an EMHP to transition to a CWP role, they will have most of the relevant skills and knowledge that a CWP requires, but will be lacking the in-service training to work in settings wider than education; this could be addressed through placements or in-service training.

For HEIs to offer top-up programmes, there would need to be evidence of sufficient demand, given the additional resources required to deliver this. Collecting this evidence is not straightforward; discussion with the London programme directors indicates that very few trainees have transferred from an initial training in one programme to another, though the possibility of fast-tracking between the programmes might present a more attractive option and influence demand.

In addition, there may be difficulties finding the resources to supervise trainees on a top-up route, bearing in mind that programmes already report that finding suitably qualified supervisors represents a significant logistical constraint. Although some HEIs have funded initiatives around supporting CWPs to become supervisors, this would still fall short of the required number. This may, in turn, make HEIs reluctant to offer a top-up programme.

Any efforts to create an efficient training route that enables transition between the CWP and EMHP roles will have to be flexible and adaptive to the evolving contexts these roles sit in. As the roles are still new, they are continuously developing and changing, and they may look different now compared with a few years in the future, when they become more established. Regular reviews of the differences between the roles should be an integral part of any initiatives aiming to increase the efficiency of training routes in this area, in order to ensure that content of top-up training remains appropriate.

6.2. Further recommendations

- Further clarity is needed for both the CWP and EMHP roles; both would benefit from clearer and more comprehensive definitions. Although these roles are new and still developing, there may be confusion about the distinction between them and this could cause uncertainty for trainees who are applying to these positions.
- There is a need to identify the demand for top-up training and to understand why there is demand for this. If it is motivated by a lack of available positions and/or career prospects, then it may be helpful to consider the opportunities for employment and for career development associated with these roles. This will contribute to improved staff retention.
- Consideration should be given to ways in which the CWP and EMHP programmes could be amended and developed to be more closely aligned. This could include the option of the CWP programme emphasising work in clinical settings and the EMHP programme emphasising work in educational settings, with a clearer top-up route between the two roles constituted by training in, and experience of, work in the other setting.
- Both CWP and EMHP courses should work towards obtaining professional accreditation for the roles, bringing them in line with the PWP role. The possibility of back-dating formal accreditation for CWPs and EMHPs who have already completed the training should be explored. Professional accreditation may also be a reason for trainees being drawn to one course over another.

Abbreviations

Abbreviation	Full term
BPS	British Psychological Society
CBT	cognitive behavioural therapy
CWP	children's wellbeing practitioner
CYP IAPT	children and young people's Improving Access to Psychological Therapies
EMHP	education mental health practitioner
HEE	Health Education England
HEI	higher education institution
IAPT	Improving Access to Psychological Therapies
MHST	mental health support team
NICE	National Institute for Health and Care Excellence
PWP	psychological wellbeing practitioner
SENCO	special educational needs coordinator

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Appendix

Summary of the stakeholder consultation

Course training leads were invited to comment on the accuracy of the matrix and its applicability to their own programme. Their comments were recorded, individually reviewed and responded to by at least one member of the NCCMH research team. Comments for which there were any conflicting views were discussed with the wider project team to agree a consensus response or action. Here we provide a summarised version of changes made to the matrix as a result of the consultation.

Course characteristics

Entry requirements

Entry requirements for adult PWP courses were widened to include those that may offer places to people with level 5 or 6 qualifications and as such can be studied at level 6 or 7. This is supportive of widening participation and increasing diversity within the workforce.

Duration of training

We referenced the potential for variability between adult PWP courses regarding duration of training depending on differences to do with scheduling. For example, some courses include training/teaching during non-term dates (such as school summer holidays) and as a result, training can last less than one year.

Contract type was expanded to include both fixed-term and permanent contracts given that this differs between courses.

Length and rate of training

Training as an adult PWP within an IAPT service was changed to state that this was the 'ideal' given that supervised practice can occur in any other fully functioning and appropriate service as long as it operates according to and in line with the requirements of working in IAPT.

Full-time or part-time

Adult PWP training can be undertaken either full-time or part-time so this was clarified. Only some opportunities for part-time CWP courses exist and this is asterisked within the matrix.

Supervision

For adult PWP, we added that the required supervision (40 hours) needs to occur within the service in which the placement is located.

Duration of supervised practice and number of cases

The requirement to demonstrate competence working with patients both in face-to-face situations and by telephone as an adult PWP was added. This includes the requirement for demonstration of both competences to be signed-off by a supervisor.

We have specified that the 80 clinical contact hours required for adult PWP trainees can be made up of a mix of face-to-face, telephone, one-to-one or group work within an IAPT service.

Evaluation methods

EMHP and children and young people's course evaluation methods were widened to be more generic and accurately reflect the variability between training courses. We have listed the broad

categories of academic assignments, clinical assignments and competency assessments, each with supported by examples. The requirement for a written report on 'measuring wellbeing in schools' specific to EMHP evaluation remains.

Qualification received

The qualification received will be dependent on individual programmes. This stipulation was added to include courses offering different qualifications depending on an individual's education level at entry, as appropriate. We added that some courses offer a graduate as well as post-graduate level certificate.

Clinical context

As with *Length and rate of training* (above), the context for training as an adult PWP states an IAPT service as the ideal while recognising that any service operating in line with IAPT practices, procedures and requirements is sufficient.

List of organisations involved

British Psychological Society

Edge Hill University

Health Education England

Newcastle University

Northumbria University

Sheffield University

University of Central Lancashire

University of East Anglia

University of Exeter

University of Sunderland

University of Sussex